STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155170		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/27/2012	
	PROVIDER OR SUPPLIE		5801 W	ADDRESS, CITY, STATE, ZIP CODE / BETHEL AVE E, IN 47304	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was State Licensu Survey dates: 27, 2012 Facility number Provider number: Survey team: Betty Retherfor Ginger McNarkaren Lewis, Census bed ty SNF: 56 Residential: 1 Total: 242 Census payor Medicare: 17 Other: 225 Total: 242 These deficient findings cited IAC 16.2.	for a Recertification and re Survey. July 22, 23, 24, 25, 26, er: 000086 per: 155170 N/A ord, RN, TC mee, RN RN /pe:	F0000	DEFICIENCE 1	DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIIII	DING	00	COMPLETED	
		155170	A. BUII			07/27/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		_
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
MECTAL	NOTED VIII AGE A	ALINICIE INIC			BETHEL AVE		
WESTIMI	NSTER VILLAGE N	IUNCIE INC		MUNCI	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0282 SS=D	CARE PLAN The services pro facility must be p in accordance w plan of care. Based on record interview, the farms a resident with infections and/or abnormal lab te	acility failed to monitor known urinary tract or follow-up on est results in	F02	82	Westminster Village Muncie, Inc. Plan of Correction F- 28 Services by Qualified Persons/per Care Plan (Labs 1) What corrective actions(s) will be accomplish	,	2
	accordance with the resident's plan of care, for 2 of 10 residents reviewed			for those Residents found to have been affected by			
	for timely labor	atory services and/or			the alleged	450	
	monitoring of a	change in condition.			deficient practice: Resident a clinical records were reviewed		
	(Resident #'s 5	3 and 62)			The physician was notified and		
	,	,			antibiotic started on July 24,		
	Findings includ	e:			2012. Resident #62 clinical records were reviewed for labs	3.	
	1.) The clinical	record for Resident			All labs and physician notificat	ion	
	·	ved on 7/24/12 at 1:35			documented on clinical record. Although there was a b	riof	
	p.m.				delay in treatment (3 days) for		
	F				Resident #53, it should be note	ed	
	Diagnoses for I	Resident #53 included,			there is not any adverse effect	•	
	_	nited to, history of			from alleged deficient practice	2)	
		-			How other Residents having		
	urinary tract inf	•			the potential to be affected b	у	
		y retention, and renal			the same alleged deficient	,	
	aortic aneurysr	n.			practice will be identified and what corrective actions(s) wi	•	
					be taken: All residents with la		
	The clinical rec	ord indicated Resident			orders have been reviewed for		
	#53 had an ord	ler for a size 16 foley			results and Physician		
	catheter due to	a problem with urinary			notification. A meeting with Me	d	
	retention. The				Lab Services has been schedu		
	indicated the re	esident was treated			for August 13, 2012 at 9:30 a.r	n.	
		herapy for a urinary			to discuss the method of		
			I		operation for communication		

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Event ID: T3ZQ11

Facility ID: 000086

If continuation sheet

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STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLI	ETED
		155170	B. WIN			07/27/2	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
VA/ECTAI	NOTED VIII ACE N	ALINICIE INIC			BETHEL AVE		
VVE3 I IVII	NSTER VILLAGE N	NUNCIE INC		MONCI	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	tract infection i	n late March of 2012.			purposes. This is in an effort t	ю)	
					avoid the alleged deficient		
	A health care plan problem, dated				practice from re-occurring.3)		
					What measures will be put in	ito	
	5/29/12, indicated Resident #53 was				place or what systemic		
	at risk for urinary tract infections (UTI)				changes will be made to		
	related to an indwelling catheter and				ensure that the alleged		
	diagnosis of urinary retention.				deficient practice does not	_	
	Approaches for this problem included,				recur: Audits will be preforme		
	but were not limited to, "Labs as ordered" and "Monitor for signs and				on labs and physician notificat on a weekly basis. Staff nurse		
					will be required to review and		
	symptoms of UTI:suprapubic pain,				initial lab requisitions that resu	lts	
					have been received and physi		
	dysuria, pyuria, foul smelling urine,				was notified within 24 hours.		
	flank tenderness, hematuria, fever,				Culture notification to physicia	n	
	concentrated urine, dehydration, or				must be made upon receiving		
	changes in cog	nitive ability and report			results. In-Servicing will occur	for	
	to medical doc	tor as needed."			all Nurses by August 14, 2012		
					In-Services will include Lab Po	-	
	A recapitulation	n of physician's orders,			and Procedure, Documentatio		
		ndicated Resident #53			Physician Notification and Ord		
	· ·	or a urinalysis and			Review. A meeting with Med L		
		-		Services has been scheduled for			
		nsitivity (UA C&S) test		August 13, 2012 at 9:30 a.m. to discuss the method of operation			
		nthly to monitor for			for communication purposes.	···	
	urinary tract inf	fections. The original			This is in an effort to avoid the		
	date of this ord	ler was 3/20/12.			alleged deficient practice from		
					re-occurring. 4) How the		
	A UA C&S fina	I report, dated 6/8/12,			corrective action(s) will be		
		dent #53 had blood and			monitored to ensure the		
		urine. The report			alleged deficient practice wil	1	
					not recur, i.e. what quality		
		rine was positive for			assurance program will be p	ut	
		(lebsiella Pneuomniae.			into place: Unit Managers or		
	· •	ed 13 antibiotics to			designee will perform weekly		
	which the orga	nism was sensitive. A			audits that labs have been	od	
	notation on the	report indicated it was			completed and physician notifi in a timely manner to ensure	eu	
		ysician on 6/8/12.			quality care. The QA Committ		
		,			will review the results monthly		
	l		1		I		

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Event ID: T3ZQ11

Facility ID: 000086

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETI	ED
		155170	B. WIN			07/27/20	12
			э. W II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC			E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The clinical rec	cord lacked any			12 months and modify the aud		
	documentation	of the fax being			system as necessary to mainta		
	received by the physician on 6/8/12 or				compliance. 5) All compone of the systematic adjustment		
	any follow up n	otification and/or			for notification of changes w		
	monitoring hav	ing been completed by			be implemented by August 1		
	the nursing staff on 6/8/12, 6/9/12 or				2012.		
		I to the abnormal lab					
	report . The clinical record indicated						
	the physician was aware of the lab						
	report on 6/11/12 and an order was						
	•	nentin (an antibiotic)					
	-						
	675 milligrams	twice daily for 10 days.					
	This resulted in	n a time period of 3					
		date the final lab report					
	1 -	and the physician was					
		onormal laboratory					
		eatment was ordered.					
	indings and tre	cament was ordered.					
	A urinalysis rep	oort, dated 7/4/12,					
	indicated the re	esident's urine was					
	positive for leu	kocytes. A notation on					
	the lab report r	nade by the physician,					
		ndicated the physician					
	was "awaiting (. ,					
	A C&S final rer	oort, dated 7/7/12,					
	·	esident's urine was					
	positive for the						
		aecalis. The report					
		tics to which the					
	_	sensitive. The nursing					
		ny monitoring of the					
		d to the abnormal					
	culture and ser	nsitivity report from					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155170	A. BUILDING B. WING		07/27/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	ER		V BETHEL AVE	
 WESTMI	NSTER VILLAGE	MUNCIE INC		IE, IN 47304	
VVLOTIVII					
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	7/7/12 through	า 7/24/12.			
	The clinical re	cord lacked any			
	information re	lated to the physician			
		nade aware of the			
	_	S report prior to 7/24/12.			
		ed 7/24/12, was written			
	, ·	laboratory report for the			
		given Macrobid (an			
		•			
		milligrams twice daily			
	for 10 days.				
	This resulted in a time period of 17				
	days from the	dated the C&S report			
	was received	and the physician was			
	notified of the	abnormal results.			
	During an inte	rview, on 7/25/12 at			
	_	nit Manager #1			
	•	had no information to			
		d to the lack of follow-up			
	•	•			
		ed on 6/8/12. She			
		nursing staff had failed			
		hysician of the 7/7/12			
	laboratory rep	ort until 7/24/12.			
	2.) The clinical	al record for Resident			
	#62 was revie	wed on 7/24/12 at 4:10			
	p.m.				
	'				
	Diagnoses for	the resident included,			
	_	imited to, chronic kidney			
	_	e 2, acute kidney failure,			
		p vein thrombosis and			
	I pulmonary em	nbolism, anemia of renal			

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Facility ID: 000086

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155170	B. WIN	G		07/27/	2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
MECTAL		ALINICIE INC			BETHEL AVE		
	NSTER VILLAGE N	NUNCIE INC		MUNCI	E, IN 47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE	
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
1710		lemia, and chronic		ing	<u> </u>		DATE
	pancreatitis.	icilia, and cinonic					
	paricicatitis.						
	A health care plan problem, dated 10/4/11 and last reviewed on 7/25/12, indicated the resident had a "potential"						
	for fluid volume excess, mental status						
	changes, injury, altered nutritional						
	status, decrease of increase in urine						
	output, hypotension, dry mucous						
	membranes, and infection related to						
	renal failure." One of the approaches for this problem was "Labs as ordered						
	and notify med	ical doctor of results."					
	•						
	A health care p	olan problem, dated					
	3/16/11 and las	st reviewed on 7/25/12,					
	indicated Resid	dent #62 was at risk for					
	increased bruis	sing and bleeding					
	related to Cour	madin (a medication					
	given to thin th	e blood) use. One of					
	the approaches	s for this problem was					
	"Lab levels as	ordered, notify					
	physician of re	sults."					
		ad physician's orders,					
	_	for a CBC (complete					
	blood count), C	• •					
		le), and PT/INR					
	••	me and international					
	, ,	one to monitor the					
		blood) to be done					
	· ·	n Mondays and					
	Thursdays.						

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Facility ID: 000086

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155170	A. BUILDING B. WING		07/27/2012
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE V BETHEL AVE	
WESTMI	NSTER VILLAGE N	MUNCIE INC		IE, IN 47304	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
	CMP, and PT/II dated 7/16/12 a clinical record I these tests have Thursday 7/19/I lacked any information nursing staff formissing laborated. The clinical recording resident's Courbeen changed 7/17/12 based The last order of indicated the recommadin 1.5 and a last order of indicated the recommadin 1.5 and a last order of indicated the recommadin 1.5 and a comparative which included drawn on 7/19/7/19/12 indicated themoglobin and done to monito level, protein lewere all "low". report indicated "high". During an interior of the second process of the protein lewere all "low".	ord contained CBC, NR laboratory reports and 7/23/12. The acked any report for ring been sent on 12. The clinical record rmation related to the llowing up on the cory report. ord indicated the madin medication had on 7/10, 7/12, and on the PT/INR reports. change, dated 7/17/12, esident was to receive milligrams every other with 2 milligrams on orts for the above ted 7/23/12, contained section on the reports results from the labs 12. The results for ed the resident's d hematocrit (tests r anemia), calcium evel, and albumin level The resident's PT/INR d the levels were			

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Facility ID: 000086

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETI	
		155170	B. WIN	G		07/27/20	12
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
VA/E O TA 41	NOTED VIII AGE A	ALINIOIE INIO			BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC		MUNCIL	E, IN 47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) OMPLETION
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ED TO THE APPROPRIATE	
TAG		,		TAG	DEFICIENCY)		DATE
	she was unable	ated to the 7/19/12 lab					
	reports having been received by the						
	facility prior to the comparative section information noted on the						
	7/23/12 lab report. She indicated she						
	had no information to provide related						
	to the physician having been made						
	aware of the abnormal 7/19/12 lab						
		e blood test reports for					
		2 were received which					
	contained the comparative information. 3.) The undated procedure for						
	1 '	atory orders" was					
	provided by the	-					
	'	on 7/27/12 at 11:05					
		edure indicated a copy					
	•	aboratory] will be sent					
		s physician and one to					
		nter for inclusion in the					
	resident's med	ical record. This copy					
		d on the chart. If the					
	lab results are	abnormal, contact the					
	physician's offi	ce to verify receipt of					
	the results.						
	1	ed procedure for					
		ange, of the Resident					
	(Observing, Re	•					
		s provided by the					
		inistrator on 7/27/12 at					
		e procedure indicated it					
		responsibility of the					
	licensed nurse	to document the date					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WESTMINSTER VILLAGE MUNCIE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304 (X5)		OF CORRECTION	IDENTIFICATION NUMBER: 155170	(X2) MULTIPLE CC A. BUILDING B. WING	00	COME	E SURVEY PLETED 7/2012
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and time the condition change was identified. The procedure indicated an observation of the resident should be documented at least every shift until the condition is stable by the COMPLETIC CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG COMPLETIC CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETIC CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG COMPLETIC CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE				STREET A	BETHEL AVE	P CODE	
identified. The procedure indicated an observation of the resident should be documented at least every shift until the condition is stable by the	PREFIX	(EACH DEFICIEN REGULATORY OR	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETION
3.1-35(g)(2)		identified. The an observation be documented until the condit licensed nurse	procedure indicated of the resident should d at least every shift ion is stable by the				

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Event ID: T3ZQ11

Facility ID: 000086

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155170	B. WING		07/27/2012
		<u> </u>	_	T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF			W BETHEL AVE	
WESTMI	NSTER VILLAGE N	MUNCIE INC		CIE, IN 47304	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE CONTRIBETION
		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG F0309 SS=D	483.25 PROVIDE CARE WELL BEING Each resident m must provide the services to attain practicable phys psychosocial we the comprehens care. Based on recon interview, the for a resident was insulin sliding sordered for 1 or for accuracy of coverage. (Reference of the comprehens) Coverage. (Reference of the coverage of th	E/SERVICES FOR HIGHEST ust receive and the facility e necessary care and n or maintain the highest ical, mental, and III-being, in accordance with ive assessment and plan of rd review and acility failed to ensure given the accurate scale coverage as f 3 residents reviewed insulin sliding scale sident #50) ie: I record for Resident ived on 7/27/11 at Resident #50 included, mited to, diabetes congestive heart	F0309	Westminster Village Muncie Inc. Plan of Correction F-Provide Care/Services for Highest Wellbeing (insulin sliding scale) 1) Vicorrective actions(s) will be accomplished for those Residents found to have be affected by the alleged deficient practice: Resident clinical records were reviewed physician notified with no negative outcome. 2) Hower Residents having the potent to be affected by the same alleged deficient practice who be identified and what corrective actions(s) will be taken: All insulin dependent Residents' clinical records have been reviewed for accuracy. Documentation of all resident with sliding scales have been reviewed for accuracy and whound to be in compliance at time. 3) What measures with put into place or what systemic changes will be made to ensure that the allegations and control of the place or what systemic changes will be made to ensure that the allegations are supported to the province of the province o	on the state of th
	-	inister medications as		deficient practice does not recur: Unit Managers or	
				designees will monitor all	

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155170		LDING		07/27/	′2012
			B. WIN		PDDEGG CVTV GTATE JID GODE		_
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC		MUNCII	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	ordered and m	onitor blood glucose as			Residents with sliding scale		
	ordered.				insulin coverage to ensure the		
					alleged deficient practice does		
	Resident #50 had physician's orders				not reoccur. In-Services will	. 4.4	
	for the following,				occur for all Nurses by August 2012. In-Services will include		
	for the following,				Policy and Procedures,	Lau	
	A AA '' 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				Documentation, Physician		
	A. Monitor blood sugar results 4 times				Notification and Order Review		
	daily at 7:00 a.m., 11:00 a.m., 4:00				4) How the corrective action		
	p.m., and 8:00 p.m. The original date				will be monitored to ensure t		
	of this order was 7/5/11.				alleged deficient practice wil	ı I	
					not recur, i.e. what quality		
	B. Administer Lantus insulin 10 units				assurance program will be p	ut	
	subcutaneously at bedtime. The				into place: Unit Managers or		
	original date of this order was 9/7/11.				designees will monitor all		
	original date of	this order was 9/7/11.			Residents with sliding scale		
					insulin, coverage weekly for 3		
	C. Administer I	Humalog sliding scale			months and then monthly for 9)	
	insulin accordir	ng to blood sugar			months to ensure quality care. The Quality Assurance		
	results as listed	d below,			Committee will review the resu	ılte	
					monthly for 12 months and mo		
	141 - 180 = 1 ເ	ınit			the audit system as necessary	-	
	181 - 220 = 2 เ	ınits			maintain compliance. 5) All		
	221 - 260 = 4 u				components of the systemat		
	261 - 300 = 6 u				adjustments for notification		
					changes will be implemented	d	
	301 - 340 = 7 u				by August 14, 2012.		
	341 - 380 = 8						
	381 - 420 = 9 ເ						
	421 - 460 = 10	units					
	greater than 46	60 = 12 units					
	give 1/2 the co	verage at bedtime and					
	1 -	e nearest whole					
	The original da	te of this order was					
	7/5/11.	to or time order was					
	1/3/11.						
	Dovious of the	May 2012 "Manthly					
	Keview of the I	May 2012 "Monthly					

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Event ID: T3ZQ11

Facility ID: 000086

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	COM	TE SURVEY MPLETED
		155170	B. WING		— 07/s	27/2012
	PROVIDER OR SUPPLIER		5801 V	ADDRESS, CITY, STATE, ZIP V BETHEL AVE IE, IN 47304	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	indicated the in was documente	g" for Resident #50 correct dose of insulin ed as having been llowing dates and				
	was 156, 2 unit	m., blood sugar result is of insulin was s having been given. nould have received 1				
	was 147, no ins	.m., blood sugar result sulin was documented a given. the resident ceived 1 unit.				
	was 155, 2 unit	.m., blood sugar result is insulin was is having been given. nould have received 1				
	was 142, no ins	o.m., blood sugar result sulin was documented a given. The resident ceived 1 unit.				
	result was 213, documented as	a.m., blood sugar 1 unit of insulin was having been given. hould have received 2				
	May 30, 4:00 բ	o.m., blood sugar result				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE COMPL	
		155170	A. BUII B. WIN			07/27/	2012
	PROVIDER OR SUPPLIEF			5801 W	ADDRESS, CITY, STATE, ZIP CODE BETHEL AVE E, IN 47304	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	documented as	ts of insulin was s having been given. nould have received 4					
	result was 164 documented as	p.m., blood sugar , no insulin was s having been given. nould have received 1					
	result was 220 documented as	a.m., blood sugar , 4 units of insulin was s having been given. nould have received 2					
	result was was	m., no blood sugar documented, no cumented as having					
	result was doci 244, 4 units of documented as The resident sl	p.m., blood sugar umented as 186 and insulin was s having been given. nould have received 2 ugar result was 186.					
	was 397, 4 uni documented as	o.m., blood sugar result ts of insulin was s having been given. nould have received 5					

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Event ID: T3ZQ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155170	B. WING		07/27/2012		
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE			
VA/EOTNAI	NOTED VIII A OF	MUNICIE INC	5801 W BETHEL AVE				
WESTMI	INSTER VILLAGE	MUNCIE INC	MUNCI	E, IN 47304			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG		NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE		
IAU			IAG		DATE		
	· ·	p.m., blood sugar result nsulin was documented					
	•	n given. The resident					
	_	eceived 1 unit.					
	Siloulu liave it	Cocived Fullit.					
	During an inte	rview with the Unit					
	_	n 7/27/12 at 12:20 p.m.					
		rmation was requested					
		inaccurate sliding scale					
		ing been documented					
	as given on the dates and time noted						
	above.						
	The facility fai	led to provide any					
	•	rmation as of exit on					
	7/27/12.						
	The undated "	'Blood Sugar					
		olicy was provided by					
	• .	Administrator on					
	11/27/12 at 1:	30 p.m. The procedure					
		. Check physician's					
		d sugar testing3.					
		acturer's directions for					
	the equipment	t used in your facilityIf					
		red based on a sliding					
	scale docume	nt the type and amount					
	of insulin adm	inistered and the site of					
	injection"						
	3.1-37(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLI	ETED
		155170	A. BUII B. WIN			07/27/2	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t			BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC			E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	BLADDER Based on the res assessment, the resident who ent indwelling cathet the resident's clin that catheterizati resident who is in receives approph to prevent urinar restore as much possible. Based on recon interview, the fa a resident with infections and in abnormal cultu reports in a tim prompt treatmen reviewed of the for urinary cath say 1.) The clinical #53 was review p.m. Diagnoses for lin but were not lin urinary tract infe	acility failed to monitor known urinary tract notify the physician of re and sensitivity ely manner to ensure ent for 1 of 3 residents a 4 who met the criteria neter use. (Resident # de: I record for Resident ved on 7/24/12 at 1:35 Resident #53 included, mited to, history of fections, kidney y retention, and renal	F03	15	Westminster Village Muncie, Inc. Plan of Correction F-3 No Catheter, Prevent UTI, Restore Bladder 1) What corrective actions(s) will be accomplished for those Residents found to have bee affected by the alleged deficient practice: Resident clinical records were reviewed physician notified and antibioti were started on July 24, 2012. should be noted that Nursing Staff have beenreminded durir in-service meetings that althouthe in-house Medical Director makes rounds on a weekly bashe still must be notified as we wouldwith a Primary Care Physician. The Medical Direct Physician signature folders that are kept on each unit does not alleviate pertinent phone calls andfaxed information related to abnormal labs, change of condition, etc. 2) How other Residents having the potentit to be affected by the same	#53 , cs It ng ugh sis,	08/14/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	I DDIG	00	COMPLE	TED
		155170		LDING	-	07/27/2	.012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC		MUNCI	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The clinical rec	cord indicated Resident			alleged deficient practice wil	ı l	
	#53 had an ord	der for a size 16 foley			be identified and what		
		a problem with urinary			corrective actions(s) will be		
		•			taken: All Residents' clinical		
	retention. The				records have been reviewed,		
	indicated the resident was treated with antibiotic therapy for a urinary				physician notified for lab result	ts	
					and change in condition. 3)		
	tract infection i	n late March of 2012.			What measures will be put in	ito	
					place or what systemic		
	A health care plan problem, dated 5/29/12, indicated Resident #53 was				changes will be made to		
					ensure that the alleged		
	· ·				deficient practice does not		
	at risk for urinary tract infections (UTI)				recur: Audits will be performe on labs and physician notificat		
		dwelling catheter and			on a weekly basis for 12	1011	
	diagnosis of ur	inary retention.			months. Protocol for UTI was		
	Approaches fo	r this problem included,			updated to include checking sl	hift	
	but were not lir	nited to, "Labs as			onset of systems until lab resu		
	ordered" and "	Monitor for signs and			have been obtained and/or		
		JTI:suprapubic pain,			treatment completed. In-Service	ces	
	1 .	, foul smelling urine,			will occur for all Nurses by Aug		
		_			14, 2012. In-Services will incl	ude	
		ss, hematuria, fever,			Lab Policy and Procedures,		
		ırine, dehydration, or			Documentation, Physician		
		gnitive ability and report			Notification, Protocol Update a	and	
	to medical doc	tor as needed."			Order Review. 4) How the		
					corrective action(s) will be		
	A recapitulation	n of physician's orders,			monitored to ensure the	,	
		ndicated Resident #53			alleged deficient practice will not recur, i.e. what quality	' l	
		or a urinalysis and			assurance program will be p		
		•			into place: Unit Managers or	"	
		nsitivity (UA C&S) test			designees will perform weekly		
		nthly to monitor for			audits that labs/protocol has b		
	urinary tract inf	fections. The original			completed and physician notifi		
	date of this ord	ler was 3/20/12.			in a timely manner to ensure		
					quality care. The Quality		
	A UA C&S fina	I report, dated 6/8/12,			Assurance Committee will revi		
		dent #53 had blood and			the results monthly for 12 mor		
					and modify the audit system a	s	
		urine. The report			necessary to maintain		
	I indicated the u	rine was positive for			compliance. 5) All compone	nts	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155170	B. WING		07/27/2012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MESTMI	NSTER VILLAGE M	ALINCIE INC		W BETHEL AVE CIE, IN 47304	
				/i_, ii\ +7 00+	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
		lebsiella Pneuomniae.		of the systematic adjustmen	nts
		d 13 antibiotics to		for notification of changes	
	which the organism was sensitive. A			be implemented by August	14,
	1	report indicated it was		2012.	
	faxed to the physician on 6/8/12.				
	The clinical rec	ord lacked any			
	documentation of the fax being received by the physician on 6/8/12 or any follow up notification and/or monitoring having been completed by				
		ff on 6/8/12, 6/9/12 or			
		to the abnormal lab			
	l .	nical record indicated			
		as aware of the lab			
	-	12 and an order was			
	-	entin (an antibiotic)			
	875 milligrams	twice daily for 10 days.			
	This resulted in	a time period of 3			
		date the final lab report			
		nd the physician was			
		onormal laboratory			
		eatment was ordered.			
	<u> </u>				
	A urinalysis rep	ort, dated 7/4/12,			
	indicated the re	esident's urine was			
	positive for leul	kocytes. A notation on			
	the lab report n	nade by the physician,			
	dated 7/5/12, ir	ndicated the physician			
	was "awaiting (C&S report."			
		oort, dated 7/7/12,			
		esident's urine was			
	positive for the	organism	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155170		(X2) MULTIF A. BUILDING		NSTRUCTION 00	(X3) DATE S COMPL	ETED	
		1001/0	B. WING			07/27/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WESTMI	NSTER VILLAGE M	MUNCIE INC			BETHEL AVE E, IN 47304		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCE		DATE
		aecalis. The report ics to which the					
	organism was sensitive. The nursing notes lacked any monitoring of the						
		to the abnormal					
		nsitivity report from					
	7/7/12 through						
	The clinical rec	ord lacked any					
	information related to the physician						
	having been made aware of the abnormal C&S report prior to 7/24/12.						
	An order, dated						
		the physician on the					
		ry report for the					
	_	given Macrobid (an					
	,	milligrams twice daily					
	for 10 days.						
	This resulted in	a time period of 17					
	days from the o	dated the C&S report					
		nd the physician was					
	notified of the a	abnormal results.					
	Describe as a sector (
		view, on 7/25/12 at					
	12:45 p.m., Un	it Manager #1 ad no information to					
		to the lack of follow-up					
	·	d on 6/8/12. She					
		ursing staff had failed					
		•					
	to notify the physician of the 7/7/12 laboratory report until 7/24/12. 2.) The undated procedure for						
	l '	atory orders" was					
	provided by the	-					

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Event ID: T3ZQ11

Facility ID: 000086

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155170			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2012
	PROVIDER OR SUPPLIE		STREET A	ADDRESS, CITY, STATE, ZIP CODE / BETHEL AVE E, IN 47304	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	a.m. The procoof the report [lato the resident the Health Cerresident's medis to [be] place lab results are physician's offit the results. 3.) The undate "Condition Char (Observing, Reporting" was Assistant Adm 11:05 a.m. The was the basic licensed nurse and time the condition of the condition of the condition of the condition of the documenter of the the condition of the the condition of the documenter of the the condition of the the the the condition of the	es provided by the inistrator on 7/27/12 at e procedure indicated it responsibility of the to document the date ondition change was e procedure indicated of the resident should dat least every shift ion is stable by the			

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Event ID: T3ZQ11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155170	B. WING		07/27/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		V BETHEL AVE	
MESTAIN	NSTER VILLAGE I	MUNCIE INC		IE, IN 47304	
WESTIVIII	NOTER VILLAGE I	WONCIE INC	MONC	1E, 1N 47304	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0428 SS=D	483.60(c) DRUG REGIME IRREGULAR, A The drug regime reviewed at least pharmacist. The pharmacist to the attending nursing, and the upon. Based on reco interview, the of failed to identify the potential to maximum reco drug for 2 of 10 unnecessary in #16 and #50) Findings include 1). The clinical #16 was review p.m. Diagnoses for but were not lin heart failure, b pain. Current physic Resident #16 i limited to, the fi pain:	EN REVIEW, REPORT ACT ON en of each resident must be st once a month by a licensed must report any irregularities physician, and the director of ese reports must be acted ard review and Consultant Pharmacist ify physician orders with exceed the daily ommended dose of a 0 residents reviewed for nedications. (Resident	F0428	Westminster Village Muncie, Inc. Plan of Correction F-4 Drug Regimen Review, Report Irregular, Act On 1) What corrective actions(s) will be accomplished for those Residents found to have be affected by the alleged deficient practice: Residents #16 and #20 clinical records were reviewed. A. Physician was notified of pote concern. B. Warning wattached to acetaminophen/acetaminophe combo order not to exceed 4 grams of acetaminophen per 24 hour period. C. Neither resid had more than 4 grams of acetaminophen in a 24 hour period resulting in no detrimental effect. 2) How or Residents having the potent to be affected by the same alleged deficient practice will be identified and what corrective actions(s) will be taken: As of August 10, 2012 residents having the potential exceeding the maximum daily	08/14/2012 28 ort en s' intial as en ent ther ial II

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155170	B. WIN			07/27/	2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
VA/ECTAI	NOTED VIII ACE N	ALINICIE INIC			BETHEL AVE		
WESTIMI	NSTER VILLAGE N	NUNCIE INC		MUNCI	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	that contains T	vlenol) 5/325			dose of acetaminophen (4 gra	ms	
) 1 tablet 4 times a day			in a 24 hour period) have beer	า	
	(original order date 2/28/12)				re-reviewed to prevent alleged		
					deficient practice. A written		
	l <u>-</u>				pharmacist recommendation h		
	l ' •	pain medication) 325			been made to the physician or		
	mg tablet 2 tab	lets (650 mg) 3 times a			any resident having the potent	ial	
	day as needed	for pain (original order			for the alleged deficient		
	date 1/6/09)				practice. 3) What measures w	vill	
					be put into place or what		
	a) Tylonol (a :	nain modication) 225			systemic changes will be	d	
	c). Tylenol (a pain medication) 325				made to ensure that the alleg	jea	
	_	lets (650 mg) 3 times a			deficient practice does not	dina	
	day as needed	for an elevated			recur: Staff in-serviced regard physician orders and maximur	-	
	temperature (o	riginal order date			dosage allowed for	11	
	1/6/09)				acetaminophen to avoid any		
	'				further recurrence of the allege	-d	
	d) Hydrocodo	ne (a pain medication			deficient practice. 4) How th		
					corrective action(s) will be	•	
	that contains T	•			monitored to ensure the		
	,) 1 tablet 4 times a day			alleged deficient practice wil	1	
	as needed for	pain (original order			not recur, i.e. what quality		
	date 2/28/12)				assurance program will be p	ut	
	ĺ				into place: Unit Managers wil		
	The clinical rec	cord indicated the			monitor doses of acetaminoph		
		iewed the physician's			given for those residents with	the	
	l •	• •			potential for exceeding the		
		/12 and 7/13/12. No			maximum dose of		
		ons were made related			acetaminophen on a weekly be	asis	
	to the maximur	m amount of Tylenol			and report to the Director of		
	that could safe	ly be given in a 24 hour			Nursing. Pharmacy Consultan	τ	
	period.	-			will continue to review all		
	'				acetaminophen orders of dose	:5	
	During an inter	view with Unit Manager			on a monthly basis. If any resident is exceeding 4 grams	ner	
	_	view with Unit Manager			day, the physician and Directo	•	
		at 9:54 a.m., additional			Nursing will be alerted. The	1 01	
		s requested related to			Quality Assurance Committee	will	
	the pharmacy	consultant's report and			review the results monthly for		
	lack of recomm	nendations related to			months and modify the audit		
	the Tylenol and	d the Hydrocodone			system as necessary to mainta	ain	
	,		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155170	B. WIN			07/27/2012
		1			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R			BETHEL AVE	
WESTM	NSTER VILLAGE N	MUNCIE INC			E, IN 47304	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE
		g the 6/19/12 and			compliance. 5) All compone of the systematic adjustmen	
	7/13/12 pharm	nacy reviews.				
					for notification of changes w be implemented by August 1	
	During an interview with Unit Manager				2012.	
		#2 on 7/26/12 at 11:00 a.m., she				
	indicated there were no					
	recommendations from the 6/19/12					
	and 7/13/12 ph	narmacy reviews.				
	2.) The clinical record for Resident #50 was reviewed on 7/27/11 at					
	10:06 a.m.					
	Diagnoses for	Resident #50 included,				
	_	mited to, diabetes				
		, congestive heart				
	failure, and de	•				
		monta.				
	Current physic	ian's orders for				
	1	ncluded, but were not				
		following orders for				
		ollowing orders for				
	pain:					
	a) Tylonol (a	pain medication) 325				
	, , ,	'				
	, , ,) tablet 2 tablets (650				
	, ,	edtime (original order				
	date 3/26/12)					
		, , , , , , , , , , , , , , , , , , , ,				
	. •	one (a pain medication				
		ylenol) 5/325 mg 1				
		a day (original order				
	date 5/9/12)					
	c). Tylenol (a	pain medication) 325				
	mg tablet 2 tab	olets (650 mg) every 4				

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Event ID: T3ZQ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	I DINC	00	COMPL	ETED
		155170	- 1	LDING		07/27/	2012
			B. WIN		DDDEGG CITY CTATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
\4/E0T\4/	NOTED \ /// \ A OF \$	## NOTE 1810			BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC		MUNCI	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	hours as need	ed for pain (original				·	
	order date 1/4/						
		,					
	d) Tylonol (a	noin modication) 225					
	d). Tylenol (a pain medication) 325						
	. •	olets (650 mg) every 4					
		ed for an elevated					
	temperature (o	riginal order date					
	1/4/12)						
	The clinical red	cord indicated the					
	pharmacist rev	riewed the physician's					
	-	/12 and 7/23/12. No					
		ons were made related					
		m amount of Tylenol					
	that could safe	ly be given in a 24 hour					
	period.						
	During an inter	view with the Assistant					
		on 7/27/12 at 11:54					
		Il information was					
	· ·						
	•	ted to the pharmacy					
		port and lack of					
		ons related to the					
	'	e Hydrocodone orders					
	following the 6	/19/12 and 7/13/12					
	pharmacy revie	ews.					
	The facility faile	ed to provide any					
		mation as of exit on					
	7/27/12.	maderi de er exit en					
	1121112.						
		.					
	1 '	ng Drug Handbook					
	2010 indicates the maximum daily						
	dose of Tyleno	l (acetaminophen)					
	1	eed 4000 milligrams					

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Event ID: T3ZQ11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	IDENTIFICATION NUMBER: 155170	A. BUILDING B. WING	00	COME	E SURVEY PLETED 7/2012			
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304						
NSTER VILLAGE IN SUMMARY S (EACH DEFICIEN				SHOULD BE	(X5) COMPLETION DATE			

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Event ID: T3ZQ11

Facility ID: 000086

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155170	A. BUII B. WIN			07/27/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
MECTAL	NOTED VIII ACE N	NINCIE INIC			BETHEL AVE		
WESTIMI	NSTER VILLAGE M	IUNCIE INC	MUNCIE, IN 47304				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0502	483.75(j)(1)						
SS=D	PROVIDE/OBTA	IN LABORATORY					
	SVC-QUALITY/T						
		provide or obtain laboratory					
		the needs of its residents.					
		ponsible for the quality and					
	timeliness of the		F0.5				00/14/0010
	Based on recor	d review and	F05	02	Westminster Village Muncie,		08/14/2012
	interview, the fa	acility failed to ensure			Inc. Plan of Correction F- 5		
	the quality and	timeliness of			Administration (Labs) 1) W	hat	
	laboratory servi	ices for 2 of 10			corrective actions(s) will		
	•	wed for laboratory			be accomplished for those Residents found to have bee	_	
	services. (Resident #'s 62 and 83)				affected by the alleged	"	
					deficient practice: Residents	,	
					#62 and #83 clinical records ha		
	Findings includ	e:			been reviewed and physician		
					notified of the noted concern.A	.	
	1.) The clinical	record for Resident			meeting with Med Lab Service		
	#62 was review	ed on 7/24/12 at 4:10			has been scheduled for Augus		
	p.m.				13, 2012 at 9:30 a.m. to discus	ss	
	'				the method of operation for		
	Diagnoses for t	he resident included,			communication purposes. Thi		
	_	nited to, chronic kidney			in an effort to avoid the alleged deficient practice from	ı	
		2, acute kidney failure,			re-occurring. 2) How other		
	_	_			Residents having the potenti	ial	
	-	vein thrombosis and			to be affected by the same		
	•	polism, anemia of renal			alleged deficient practice wil	,	
		emia, and chronic			be identified and what		
	pancreatitis.				corrective actions(s) will be		
					taken: All residents with lab		
	The resident ha	ad physician's orders,			orders have been reviewed for		
		for a CBC (complete			results and physician notification	on.	
	blood count), C	•			This action was completed by	:41-	
	metabolic profil	•			August 10, 2012. A meeting w	Itn	
	-				Med Lab Services has been) _{at}	
		me and international			scheduled for August 13, 2012 9:30 a.m. to discuss the metho		
	ratio) (a test done to monitor the				of operation for communication		
		blood) to be done			purposes. This is in an effort t		
	twice weekly or	n Mondays and			avoid the alleged deficient	-	

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 CO.			COMPL	ETED
		155170	B. WING	ING		07/27/	2012
		<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			BETHEL AVE		
WESTMI	NSTER VILLAGE N	ALINCIE INC			E, IN 47304		
VVLSTIVII		MONCIE INC		WONCIL	_, 111 47 304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
	Thursdays.				practice from re-occurring. 3)	_	
					What measures will be put in	ito	
	The clinical rec	cord contained CBC,			place or what systemic		
	CMP, and PT/I	NR laboratory reports			changes will be made to		
	· ·	and 7/23/12. The			ensure that the alleged deficient practice does not		
		lacked any report for			recur: Audits will be performe	d	
		ring been sent on			on labs and physician notificat		
		•			on a weekly basis. Staff nurse		
	Thursday 7/19	14.			will be required to review and		
	.				initial lab requisitions that lab		
		orts for the above			results have been received an		
	noted tests, dated 7/23/12, contained a comparative section on the reports				physician was notified within 2		
					hours. Culture notifications to		
	which included results from the labs				physician upon receiving		
	drawn on 7/19/	12. The results for			results. In-Servicing will occur for all Nurses by August 14,	I	
		ed the resident's			2012. In-Services will include	Lah	
		d hematocrit (tests			Policy and Procedure,	Lub	
	_	•			Documentation, Physician		
		or anemia), calcium			Notification and Order Review	. 4)	
		evel, and albumin level			How the corrective action(s)	,	
		The resident's PT/INR			will be monitored to ensure	the	
	report indicated	d the levels were			alleged deficient practice will	I .	
	"high".				not recur, i.e. what quality		
					assurance program will be p	ut	
	During an inter	view on 7/25/12 at			into place: Unit Managers or		
		Manager #1 indicated			designee will perform weekly		
	I	ormation to provide			audits that labs have been completed and physician notif	iod	
		•			in a timely manner to ensure	eu	
		report for the 7/19/12			quality care. The QA Commit	ee	
		en received by the			will review the results monthly		
		those results being			12 months and modify the aud		
		mparative section on			system as necessary to maint		
	the 7/23/12 lab	report.			compliance. 5) All componer		
					of the systematic adjustmen		
					for notification of changes w		
					be implemented by August 1	4,	
					2012.		
	2.) The clinica	I record for Resident					
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155170	B. WIN			07/27/	/2012
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			BETHEL AVE		
WESTMI	INSTER VILLAGE N	MUNCIE INC		1	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#83 was reviewed on 7/24/12 at 1:29						
	p.m.						
	Diagnoses for Resident #83 included, but were not limited to, hypertension,						
		ssion and anxiety.					
	A physician's order dated 7/10/12,						
	indicated Resident #83 was to have a						
	complete blood count and						
	comprehensive metabolic profile (blood tests) on 7/12/12.						
	(blood tests) of	11 1/12/12.					
	The clinical rec	cord lacked any results					
		•					
		mplete blood count					
	blood test on 7	/12/12.					
	During an inter	view with Unit Manager					
	#2 on 7/25/12	•					
		mation was requested					
		•					
		nissing complete blood					
	count blood tes	si results.					
	During an inter	view with Unit Manager					
		at 2:08 p.m., she					
	indicated	at 2.00 p.111., sile					
		lood count blood test					
	•	red, but the laboratory					
	did not draw th						
	· '	revised procedure for					
	1	diology, and other					
		vices" was provided on					
	7/27/12 at 11:0	-					
	Assistant Admi	inistrator. The					
	procedure indic	cated the facility would					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155170	A. BUILDING B. WING	00	COMPLETED 07/27/2012			
	PROVIDER OR SUPPLIER NSTER VILLAGE MUNCIE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	provide or obtain laboratory services to meet the needs of its residents. The facility would be responsible for the quality and timeliness of the services. The procedure indicated the laboratory will be responsible for reporting the results of such tests to the attending physician and a written copy was to be sent to the facility to be placed in the resident records. 3.1-49(a)						

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Event ID: T3ZQ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155170		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/27/2012	
	PROVIDER OR SUPPLIE		5801 V	ADDRESS, CITY, STATE, ZIP CODE V BETHEL AVE IE, IN 47304	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0505 SS=D	RESULTS The facility mus physician of the Based on reco interview, the fi the physician of abnormal urine reports in a time residents reviet the criteria for (Resident # 53) Findings include 1.) The clinical #53 was review p.m. Diagnoses for but were not lift urinary tract in disease, urinal aortic aneurys The clinical rece #53 had an ord catheter due to retention. A recapitulatio dated 7/3/12, i had an order fo culture and se	rd review and racility failed to ensure was notified of e culture and sensitivity nely manner for 1 of 3 ewed of the 4 who met urinary catheter use. If record for Resident wed on 7/24/12 at 1:35 Resident #53 included, mited to, history of fections, kidney ry retention, and renal	F0505	Westminster Village Muncie, Inc. Plan of Correction F-5 Promptly Notify Physician of Lab Results 1) What corrective actions(s) will be accomplished for those Residents found to have been affected by the alleged deficient practice: Resident clinical records were reviewed physician notified and antibiotistarted on July 24, 2012. Resident #62 clinical records were reviewed for lab. All labs and physician notification clinical record. Reminder discussed with Nursing staff in-service meetings by August 2012, that although in-house Medical Director makes weekl routine rounds and has signat folders on each unit, it is important to place a call to hin any other primary care physicin the contact process and reporting. 2) How other Residents having the potent to be affected by the same alleged deficient practice with be identified and what corrective actions(s) will be taken: All residents' clinical records with lab orders have be reviewed for results and physinotification. A meeting with Metab Services has been sched for August 13, 2012 at 9:30 a.	#53 ; ic s

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	д Віп	a. Building 00			ETED
		155170	B. WIN			07/27/2	2012
		1	J. 11 II		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC	MUNCIE, IN 47304				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		fections. The original			to discuss the method of		
	date of this ord	ler was 3/20/12.			operation for communication purposes. This is in an effort t		
					avoid the alleged deficient	.0	
	A UA C&S fina	ıl report, dated 6/8/12,			practice from re-occurring. 3)		
	indicated Resid	dent #53 had blood and			What measures will be put in	ito	
	bacteria in her	urine. The report			place or what systemic		
		rine was positive for			changes will be made to		
		(lebsiella Pneuomniae.			ensure that the alleged		
		ed 13 antibiotics to			deficient practice does not	_	
	1	nism was sensitive. A			recur: Audits will be performe on labs and physician notificat		
	_				on a weekly basis. Staff nurse		
notation on the report indicated it was faxed to the physician on 6/8/12.				will be required to review and	,3		
	l laxed to the ph	lysician on 6/8/12.			initial lab requisitions that resu	lts	
	l				have been received and physi		
		cord lacked any			was notified within 24 hours.		
		of the fax being			Culture notification to physicia	n	
	received by the	e physician on 6/8/12 or			upon receiving		
	any follow up n	notification having been			results. In-Servicing will occu	r	
	completed by t	he nursing staff on			for all Nurses by August 14, 2012. In-Services will include	Lah	
	6/8/12, 6/9/12	or 6/10/12 related to			Policy and Procedure,	Lab	
	the abnormal la	ab report . The clinical			Documentation, Physician		
		ed the physician was			Notification and Order Review	. 4)	
		b report on 6/11/12			How the corrective action(s)		
	and an order w	•			will be monitored to ensure t		
	Augmentin (an	•			alleged deficient practice wil	<i>'</i>	
	, ,	e daily for 10 days.			not recur, i.e. what quality		
	i ililligiailis twic	c daily for 10 days.			assurance program will be p into place: Unit Managers or	ul	
	This requited in	a a time period of 2			designee will perform weekly		
		n a time period of 3			audits that labs have been		
	1 ,	date the final lab report			completed and physician notifi	ied	
		and the physician was			in a timely manner to ensure		
		bnormal laboratory			quality care. The QA Committ		
	findings and tre	eatment was ordered.			will review the results monthly		
					12 months and modify the aud		
	A urinalysis rep	oort, dated 7/4/12,			system as necessary to mainta compliance. 5) All componer		
	indicated the re	esident's urine was			of the systematic adjustmen		
	positive for leu	kocytes. A notation on			for notification of changes w		
	<u> </u>	•			l		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155170	B. WIN			07/27/2012	
			Б. WП		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			BETHEL AVE		
WESTMI	NSTER VILLAGE N	MUNCIE INC	MUNCIE, IN 47304				
					L, III 47304		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	the lab report n	nade by the physician,			be implemented by August 1	4,	
	dated 7/5/12, indicated the physician was "awaiting C&S report." A C&S final report, dated 7/7/12,				2012.		
		esident's urine was					
	positive for the						
	-	_					
		aecalis. The report					
		ics to which the					
	organism was	sensitive.					
	The clinical rec	•					
	information rela	ated to the physician					
	having been m	ade aware of the					
	abnormal C&S	report prior to 7/24/12.					
	· ·	aboratory report for the					
		given Macrobid (an					
	· · · · · · · · · · · · · · · · · · ·	•					
	,	milligrams twice daily					
	for 10 days.						
		a time period of 17					
	days from the o	dated the C&S report					
	was received a	nd the physician was					
	notified of the a	abnormal results.					
	During an inter	view, on 7/25/12 at					
	12:45 p.m., Un						
	•	nad no information to					
	•	to the lack of follow-up					
		d on 6/8/12. She					
		ursing staff had failed					
	to notify the ph	ysician of the 7/7/12					
	laboratory repo	ort until 7/24/12.					
	, ,						

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PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155170		A. BUILDING O O O O O O O O O O O O O		COMPLETED 07/27/2012		
		133170	B. WING			2012
NAME OF F	PROVIDER OR SUPPLIEF	ł		ADDRESS, CITY, STATE, ZIP CODE	Ė	
WESTMI	NSTER VILLAGE N	MUNCIE INC		W BETHEL AVE CIE, IN 47304		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
IAU	The undated pollaboratory order the Assistant A 7/27/12 at 11:0 indicated a coppliant [laboratory] will resident's physhealth Center resident's mediate to [be] placed lab results are	rocedure for "Routine ers" was provided by dministrator on 5 a.m. The procedure by of the report	F0505	Westminster Village Mun Inc. Plan of Correction Promptly Notify Physicia Lab Results 1) What corrective actions(s) will be accomplished for tho Residents found to have affected by the alleged deficient practice: Resid clinical records were revie physician notified and anti started on July 24, 2012. Resident #62 clinical records were reviewed for All labs and physician noti on clinical record. Remind discussed with Nursing sta in-service meetings by Au 2012, that although in-hou Medical Director makes w routine rounds and has sig folders on each unit, it is important to place a call to any other primary care phy in the contact process and reporting. 2) How other Residents having the pot to be affected by the san alleged deficient practice be identified and what corrective actions(s) will taken: All residents' clinic records with lab orders ha reviewed for results and p notification. A meeting with Lab Services has been so for August 13, 2012 at 9:3 to discuss the method of operation for communicati purposes. This is in an eff avoid the alleged deficient practice from re-occurring	F-505 n of se been ent #53 wed, biotic al labs. fication er aff gust 14, se eekly gnature b him as ysician l tential ne e will be cal ve been hysician n Med heduled 0 a.m. on fort to	08/14/2012

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PRINTED: 08/15/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155170	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED 07/27/2012		
		100170	B. WING		0112112012		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 5801 W BETHEL AVE MUNCIE, IN 47304				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE		
				What measures will be put place or what systemic changes will be made to ensure that the alleged deficient practice does not recur: Audits will be perform on labs and physician notific on a weekly basis. Staff nur will be required to review an initial lab requisitions that rehave been received and phy was notified within 24 hours. Culture notification to physician upon receiving results. In-Servicing will oct for all Nurses by August 14, 2012. In-Services will include Policy and Procedure, Documentation, Physician Notification and Order Reviethow the corrective action will be monitored to ensure alleged deficient practice was not recur, i.e. what quality assurance program will be into place: Unit Managers of designee will perform weekly audits that labs have been completed and physician no in a timely manner to ensure quality care. The QA Comm will review the results month 12 months and modify the an system as necessary to main compliance. 5) All componion of the systematic adjustment for notification of changes be implemented by August 2012.	ened sation sees d sults sician cur de Lab ew. 4) s) e the vill put or y tified e inttee ly for udit ents ents ents will		

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155170	B. WING		07/27/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			/ BETHEL AVE	
WESTMI	NSTER VILLAGE M	IUNCIE INC		IE, IN 47304	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0514	483.75(I)(1)				
SS=D	RES				
		IPLETE/ACCURATE/ACCE			
	SSIBLE	maintain alinical records on			
	I	maintain clinical records on accordance with accepted			
		ndards and practices that are			
		ately documented; readily			
		systematically organized.			
		, , ,			
	The clinical reco	rd must contain sufficient			
		entify the resident; a record			
		assessments; the plan of			
		s provided; the results of any			
		reening conducted by the			
	State; and progre		F0514		00/14/2012
	Based on recor	d review and	F0514	Westminster Village Muncie,	
	interview, the fa	acility failed to ensure		Inc. Plan of Correction F- 5	14
	hospice nursing	g documentation		Records -	Na.
	(Resident #16)	and weekly weights		Complete/Accurate/Accessit (Hospice and weekly	oie
	, ·	were documented in		weights) 1) What corrective	
	, , ,	ord for 1 of 1 resident		actions(s) will be accomplish	
		ospice services and for		for those Residents found	ileu
		s reviewed of the 14		to have been affected by the	
				alleged	
		met the criteria for		deficient practice: Resident	#16
	nutritional servi	ces.		clinical records were reviewed	
				Hospice was notified. All note	
	Findings includ	e:		obtained from Hospice Service	
				are on clinical record. Resider	nt
	1.) The clinical	record for Resident		#83 clinical records were	
	#16 was review	ved on 3/7/12 at 2:11		reviewed. The weights have been recorded in the clinical	
	p.m.			record as a late entry. 2) Hov	,
	-			other Residents having the	
	Diagnoses for F	Resident #16 included,		potential to be affected by the	ne
	•	nited to, congestive		same alleged deficient pract	
				will be identified and what	
		polar disorder, and		corrective actions(s) will be	
	pain.			taken: All Residents' clinical	
				records on Hospice with service	res

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLI			ETED	
		155170	A. BUII B. WIN			07/27/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2					
\A/EOT\AI	NOTEDIALIAGE	ALINIOLE INIO			BETHEL AVE		
WESTIMI	NSTER VILLAGE N	JUNCIE INC		MUNCI	E, IN 47304		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The clinical rec	ord for Resident #16			have been reviewed for		
	lacked any documentation for				appropriate documentation.		
	1	ice nursing visits.			Documentation is on the chart		
					effort to provide continuity of c	are	
	During an inter	view with Unit Manager			from all providers. 3) What measures will be put into pla	000	
		at 2:45 p.m., additional			or what systemic changes w		
		•			be made to ensure that the		
		s requested related to			alleged deficient practice do	es	
		tion of hospice nursing			not recur: Designee will repo		
	visits.				to Unit Managers any weekly		
					weights not obtained. Unit		
	During an interview with Unit Manager				Managers will audit weekly that	at	
	#2 on 7/27/12 at 8:15 a.m., she				weights were obtained and		
	indicated there was no documentation				documented in the clinical	n.,	
	of the hospice	nursing visits in the			records through computer entr reports. 4) How the	у	
	resident's char	_			corrective action(s) will be		
	Toolaging onlan	•			monitored to ensure the		
	2 \ The clinica	I record for Resident			alleged deficient practice wil	ı I	
	l '	ved on 7/24/12 at 1:29			not recur, i.e. what quality		
		ved 011 7724/12 at 1.29			assurance program will be p	ut	
	p.m.				into place: Unit Manager will		
					monitor on a weekly basis. The		
	1	Resident #83 included,			Quality Assurance Committee		
	but were not lir	nited to, hypertension,			review the results monthly for months and modify the audit	12	
	arthritis, depres	ssion and anxiety.			system as necessary to mainta	ain	
					compliance. 5) All componer		
	The clinical rec	ord for Resident #83			of the systematic adjustment		
	lacked any doc	cumentation of weekly			for notification of changes w		
	1	3/12 and 6/22/12.			be implemented by August 1	4,	
	1.0.9.1.0 101 0/ 1	C G. G. G			2012.		
	During an inter	view with Unit Manager					
		at 2:08 p.m., additional					
		s requested related to					
		ghts for 6/13/12 and					
	6/22/12.						
	During an inter	view with Unit Manager					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DII	ILDING	00	COMPI	LETED		
		155170	B. WI			07/27	/2012		
			D. 111		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIE	ER		5801 W BETHEL AVE					
WESTMI	WESTMINSTER VILLAGE MUNCIE INC			MUNCIE, IN 47304					
					_,				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	,	(X5)		
PREFIX	``	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	+	OR LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE		
		at 10:55 a.m., she							
	indicated the	weekly weights for							
	6/13/12 and 6	/22/12 were not							
	documented in the resident's clinical								
	record, only on the 24 hour report								
	1	ndicated the 24 hour							
		were not part of the							
	resident's clin	•							
	1								
	,	ed 5/98, "Clinical							
	records policy	" was provided by the							
	Assistant Adm	ninistrator on 7/27/12 at							
	11:05 a.m., ar	nd indicated the records							
	must be comp	lete and accurately							
	documented.	,							
	3.1-50(a)(1)								
	3.1-50(a)(2)								
	1		ı		I		I		

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